PM FORM 7.4.1
INCIDENT/ACCIDENT/DEATHS REPORT FORM

INSTRUCTIONS:

1. Complete all sections of this form. Information provided must be either typed or printed.
2. Incidents, accidents and deaths occurring in facilities licensed by the ADHS Office of Behavioral Health Licensure (OBHL) must be verbally reported to OBHL (602-364-2595) within 24 hours and reported in writing to OBHL (Fax 602-364-4801) within 5 working days.
3. Incidents accidents and deaths must be reported in writing to the RBHA or TRBHA within 48 hours.

Behavioral Health License#: _____Classification: _____Tracking ID#: _____

TYPE OF REPORT: Check all that apply.

- ☐ Death
- ☐ Suicide
- ☐ Homicide
- ☐ Accident
- ☐ Other _____

- ☐ Suicide attempt

- ☐ Accident/injury
  - ☐ In treatment setting
  - ☐ Outside treatment setting

- ☐ Self Abuse

- ☐ Human/Civil rights Violation/Allegation
  - ☐ Physical Abuse/Allegation
  - ☐ Sexual Abuse/Allegation
  - ☐ Human/Civil Rights Violation/Allegation
  - ☐ Neglect
  - ☐ Exploitation
  - ☐ Mistreatment
  - ☐ Corporal punishment
  - ☐ Unreasonable use of force/Threat of force
  - ☐ Mental/verbal abuse
  - ☐ Threat of transfer/Transfer for punishment
  - ☐ Retaliatory Acts (against a client)
  - ☐ Medication as punishment
  - ☐ Use of restraint or seclusion as punishment
  - ☐ Commercial exploitation
  - ☐ Mistreatment of a client incited or encouraged
  - ☐ Use of restraint or seclusion for the convenience of staff

- ☐ Medication errors/reactions
- ☐ Errors in dispensing
- ☐ Adverse reactions to meds

- ☐ Facility incidents
  - ☐ AWOL
  - ☐ Physical Plant Disasters
  - ☐ Crimes committed on the premises

Additional Reports Required by the RBHA or ASH:

Date & Time of Incident/Accident: _____

Address & Location of Incident: _____

Reporter's Name/Title: _____

Service Provider Name: _____

Name and Time Supervisor Notified: _____

Individual involved in the incident/accident:

☐ Enrolled Person ☐ Staff ☐ Other _____

Name:_____

Address: _____ Phone: _____

Age: _____ Sex: _____

If enrolled person: Title XIX ☐ Title XXI ☐ Non Title XIX/XXI ☐
SMI ☐ SA/GMH ☐ Child ☐

ID #: _____

Current Diagnosis: Axis I _____ Axis II _____ Axis III _____

Date of Last Visit to Psychiatrist _____ Psychiatrist Name _____

Others Involved (including witnesses):

Name: _____ Relationship to enrolled person: _____

Address: _____ Phone: _____

Name: _____ Relationship to enrolled person: _____

Address: _____ Phone: _____

Name: _____ Relationship to enrolled person: _____

Address: _____ Phone: _____

Description of incident: Describe the events leading up to and including the incident. Describe the person's physical and mental status before the incident and after the incident. Document any actions taken and/or recommendations for action.

_____

_____

_____

_____

_____

_____

_____

Reporter's Name/Title_____ Date Completed _____

Reporter's Signature _____

In Case of Incident/Accident (Requiring Medical)

If bodily injury, describe injury: _____

Who provided immediate attention: _____

Who provided medical attention: _____

If Hospitalized, Name of Hospital: _____

Address: _____

Attending Physician: _____

Medications: _____

Results: _____

_____

Date and Time of Examination: _____

Review of Incident: (REQUIRED - Completed by Supervisory Personnel.) Review all relevant information and documentation in the person's record. Ascertain objectively what occurred and document any actions you have taken and/or recommendations that you have made.

Date Received: _____

Findings: _____

_____

_____

_____

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_____

Check One:

(1) □ Report made to proper authorities, as appropriate Date of Report: _____

(2) □ Not applicable

If (1), then Specify authorities notified: _____

Supervisor's Name/Title _____ Date Completed: _____